State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

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HOUSE HEALTH AND HUMAN SERVICES

COMMITTEE ENGROSSED NO. HB1012 -

2/3/99

Introduced by: Representatives Fiegen, Cerny, Duenwald, Hagen, Hunt, Koskan, and Peterson and Senators Brosz, Ham, Kloucek, and Lawler at the request of the Interim Health and Human Services Committee

FOR AN ACT ENTITLED, An Act to provide utilization review of managed care plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. Terms used in this Act mean:

(1) "Adverse determination," a determination by a managed care plan or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the managed care plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated;

(2) "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) "Certification," a determination by a managed care plan or its designee utilization

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review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the managed care plan's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(5) "Clinical peer," a physician or other health care professional who holds a nonrestricted license in the same or similar speciality as typically manages the medical condition, procedure, or treatment under review;

(6) "Clinical review criteria," the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the managed care plan to determine the necessity and appropriateness of health care services;

(7) "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(9) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(10) "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Facility," an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings;

(12) "Health benefit plan," a policy, contract, certificate, or agreement entered into,

offered, or issued by a managed care plan to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(13) "Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(14) "Health care provider" or "provider," a health care professional or a facility;

(15) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(16) "Managed care contractor," a person who establishes, operates, or maintains a network of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan;

(17) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor that operates a managed care plan;

(18) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(19) "Necessary information," includes the results of any face-to-face clinical evaluation or second opinion that may be required;

(20) "Network," the group of participating providers providing services to a managed care plan;

(21) "Participating provider," a provider who, under a contract with the managed care plan or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the managed care plan;

(22) "Prospective review," utilization review conducted prior to an admission or a course of treatment;

(23) "Retrospective review," utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(24) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(25) "Utilization review," a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review; and

(26) "Utilization review organization," an entity that conducts utilization review.

Section 2. This Act applies to any managed care plan that provides or performs utilization review services. The requirements of this Act also apply to any designee of the managed care plan or utilization review organization that performs utilization review functions on the plan's behalf.

Section 3. A managed care plan is responsible for monitoring all utilization review activities

carried out by, or on behalf of, the managed care plan and for ensuring that all requirements of this Act and applicable rules are met. The managed care plan shall also ensure that appropriate personnel have operational responsibility for the conduct of the managed care plan's utilization review program.

Section 4. If a managed care plan contracts to have a utilization review organization or other entity perform the utilization review functions required by this Act or applicable rules, the director shall hold the managed care plan responsible for monitoring the activities of the utilization review organization or entity with which the managed care plan contracts and for ensuring that the requirements of this Act and applicable rules are met.

Section 5. A managed care plan that conducts utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program document shall describe the following:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services;

(2) Data sources and clinical review criteria used in decision-making;

(3) The process for conducting appeals of adverse determinations;

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(5) Data collection processes and analytical methods used in assessing utilization of health care services;

(6) Provisions for assuring confidentiality of clinical and proprietary information;

(7) The organizational structure that periodically assesses utilization review activities and reports to the managed care plan's governing body; and

(8) The staff position functionally responsible for day-to-day program management.

A managed care plan shall file an annual summary report of its utilization review program

activities with the director and the secretary of the Department of Health.

Section 6. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A managed care plan may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A managed care plan shall make available its clinical review criteria upon request to authorized government agencies including the Division of Insurance and the Department of Health.

Section 7. Qualified licensed health care professionals shall administer the utilization review program and oversee review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

Section 8. A managed care plan shall issue utilization review decisions in a timely manner pursuant to the requirements of this Act. A managed care plan shall obtain all information required to make a utilization review decision, including pertinent clinical information. A managed care plan shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

Section 9. A managed care plan shall routinely assess the effectiveness and efficiency of its utilization review program.

Section 10. A managed care plan's data system shall be sufficient to support utilization review program activities and to generate management reports to enable the managed care plan to monitor and manage health care services effectively.

Section 11. If a managed care plan delegates any utilization review activities to a utilization review organization, the managed care plan shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the managed care plan; and

(3) A process by which the managed care plan evaluates the performance of the utilization review organization.

Section 12. A managed care plan shall coordinate the utilization review program with other medical management activity conducted by the plan, such as quality assurance, credentialing, provider contracting data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

Section 13. A managed care plan shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

Section 14. When conducting utilization review, the managed care plan shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services.

Section 15. Compensation to persons providing utilization review services for a managed care plan may not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Section 16. A managed care plan shall maintain written procedures for making utilization review decisions and for notifying covered persons and providers acting on behalf of covered persons of its decisions.

Section 17. For initial determinations, a managed care plan shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination:

(1) In the case of a determination to certify an admission, procedure, or service, the managed care plan shall notify the provider rendering the service by telephone within

twenty-four hours of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within two working days of making the initial certification.

(2) In the case of an adverse determination, the managed care plan shall notify the provider rendering the service by telephone within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one working day of making the adverse determination.

Section 18. For concurrent review determinations, a managed care plan shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the managed care plan shall notify by telephone the provider rendering the service within one working day of making the certification; and the managed care plan shall provide written or electronic confirmation to the covered person and the provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(2) In the case of an adverse determination, the managed care plan shall notify by telephone the provider rendering the service within twenty-four hours of making the adverse determination; and the managed care plan shall provide written or electronic notification to the covered person and the provider within one working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

Section 19. For retrospective review determinations, a managed care plan shall make the determination within thirty working days of receiving all necessary information:

(1) In the case of a certification, the managed care plan may notify in writing the covered person and the provider rendering the service.

(2) In the case of an adverse determination, the managed care plan shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

Section 20. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A managed care plan shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures for a request.

Section 21. A managed care plan shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. If the provider or a covered person will not release necessary information, the managed care plan may deny certification.

Section 22. In a case involving an initial determination or a concurrent review determination, a managed care plan shall give the provider rendering the service an opportunity to request on behalf of the covered person a reconsideration of an adverse determination by the reviewer making the adverse determination.

Section 23. The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within one working day.

Section 24. If the reconsideration process does not resolve the difference of opinion, the

adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Section 25. A managed care plan shall establish written procedures for a standard appeal of an adverse determination. An appeal procedure shall be available to the covered person and to the provider acting on behalf of the covered person.

Section 26. Each appeal shall be evaluated by an appropriate clinical peer in the same or similar speciality as would typically manage the case being reviewed. The clinical peer may not have been involved in the initial adverse determination.

Section 27. For any standard appeal, the managed care plan shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty working days following the request for an appeal. The written decision shall contain:

(1) The names, titles, and qualifying credentials of the person evaluating the appeal;

(2) A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;

(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the managed care plan's position;

(4) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria; and

(5) A description of the process for submitting a grievance in writing requesting a further review of the case.

Section 28. A managed care plan shall annually provide a written certification to the director that the utilization review program of the managed care plan or its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

Section 29. In the certificate of coverage or member handbook provided to covered persons, a managed care plan shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures. A managed care plan shall include a summary of its utilization review procedures in materials intended for prospective covered persons. A managed care plan shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

Section 30. Nothing in this Act applies to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 31. If the director of the Division of Insurance and the secretary of the Department of Health find that the requirements of any private accrediting body meet the requirements of utilization review as set forth in this Act, the managed care plan may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

BILL HISTORY

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1/27/99 Scheduled for Committee hearing on this date.

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